A MEDICAL AND SOCIAL PERCEPTION OF THE VIETNAM VETERAN*

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THE Vietnam conflict, the longest and most controversial war in which our country has ever engaged, has been a strange and devastating chapter in our history.

When the United States first became involved in Southeast Asia in 1960, it was neither intended nor expected that the events there would lead to an American war. Yet, in terms of numbers of men under arms and those killed and wounded, this conflict now represents the second largest war in our history, even though combat operations from the onset have been governed by strictly limited military objectives. Above and beyond the number of people involved and the casualties, it has been a devastating war in terms of its divisive effect on our society. This and other socioeconomic factors have had a singular influence on the lives and personalities of many of our young men and women.

It now becomes important, as we appear to be reaching the end of United States involvement, for our society to provide the veterans of this conflict the maximum of assistance in readjusting to civilian life in the most constructive and productive manner possible. The Veterans Administration is the federal agency charged by statute to provide a wide range of assistance to these veterans, as well as to veterans of previous wars. And yet this is only a portion of the total responsibility of our society. In order to do the job that must be done, it is important that the characteristics, needs, and problems of the Vietnam veteran be thoroughly understood by all those who might relate to him. Especially,

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it is important that he be seen in the perspective of the war in which he has fought and of the society to which he belongs.

Since the beginning of the Vietnam era in 1964, more than eight million Americans have served in the Armed Forces—nearly twice the number who served in World War I. Of these, 55,000 have died in Vietnam, 1,500 are missing or captured, and almost a quarter of a million already have compensable service-connected disabilities. Nearly 10% of these disabilities—approximately 25,000—are 100% service-connected.[1]

All veterans who have a service-connected illness or disability become the direct and primary responsibility of the Veterans Administration. An increasing number of other veterans have sought and will continue to seek medical care within the Veterans Administration health care system as they meet certain eligibility requirements established by law. In 1968, 4% of the daily average of 83,000 patients in Veterans Administration hospitals were Vietnam-era veterans. By 1971 this number had risen to almost 13%.

As the number of Vietnam-era patients in Veterans Administration hospitals has increased, it has become more and more apparent to the staffs of those hospitals that they are dealing with a "new breed," as compared to veterans from other wars. Therefore, a series of studies was initiated to identify more accurately the needs of these new veterans, and to determine the best mechanisms for meeting them. These studies have been conducted by Vietnam Era Committees operating in each Veterans Administration hospital and clinic, by seminars and regional conferences, by a number of research studies, and by Vietnam veterans themselves.

The results of these studies have been helpful in directing the ways in which the services of the Veterans Administration should be modified in order to meet the needs of the Vietnam veteran. In addition to their effect upon hospital operations, these results have provided the basis for new approaches to the administration of the GI Education Program and other legislated benefits, and in the assumption by the Veterans Administration of broader responsibility for the development of employment opportunities and placements for veterans. The studies have also generated important information for occupational medicine as it is concerned with the total individual and his adjustment to the work-a-day world.

The Vietnam-Era Veteran

A number of characteristics of Vietnam veterans should be recognized at the outset.

First, they are the youngest veterans who have ever served. The average age for noncareer servicemen is under 26, and the majority have not reached their 22nd birthday at the time of separation from the service.

Second, they are the best educated group of any American veterans. Only 15% have not completed high school as compared to 55% for World War II and 38% for Korean veterans. More than one out of five have attended college. Relatively few, however, have had significant work experience.

Third, and perhaps most important: They are persons of high calibre. Not only have the more stringent selective service procedures filtered out the less qualified individuals, but unlike many other members of their generation, most Vietnam veterans have demonstrated the self-discipline necessary to adjust to a highly regimented way of life and to cope with the many stresses involved in military service.

Combat Casualties

Data pertaining to American casualties in Vietnam not only provide some indications of the nature of the postwar health problems of the Vietnam veteran, but also allow comparisons with the experience of prior wars.[2, 3]

When all deaths due to combat are considered,[4] it becomes apparent that in Vietnam such losses have occurred at a lesser rate than in Korea or in Europe in World War II. Among Army troops in Vietnam from July 1965 through February 1971, deaths due to all combat causes occurred at a rate of 18.0 per 1,000 average troop strength per year, as compared to a rate of 43.2 for Korea and 51.9 for the European Theater of Operations from June 1944 through May 1945 in World War II. Much higher proportions of combat deaths in Vietnam have been due to small-arms fire and to booby traps and mines than in Korea or World War II; much lower proportions have been due to artillery and other explosive projectile fragments. Analysis[5] of the causes of death of 2,600 servicemen killed in action in Vietnam indicated that 83.6%

resulted principally from wounds of the head, neck, and thorax. In most instances the primary causes of death were damage to the central nervous system, hemorrhage, or respiratory obstruction.

Of the Army servicemen wounded in Vietnam who were admitted to medical treatment facilities, 2.6% died, and 60% of the deaths occurred within 24 hours of admission. This is similar to the 2.5% mortality recorded for the Korean conflict, but distinctly lower than the 4.5% mortality in World War II.

The peculiar nature of the combat in Vietnam, the types of wounds it has produced—especially the high incidence of multiple wounds—and the excellent care which the wounded have received, have resulted in a higher incidence of certain types of complicated disability.[6] This is illustrated dramatically by the following statement made by a veteran at a regional meeting:

> One of the things that makes this war so different is the fact we couldn't tell who we were fighting half the time—I was responsible for 200 men and was in a position where I should have known but just didn't. I was injured by enemy gunfire—was shot four times, then hit by two grenades—the helicopter must have been there almost immediately. Just to give you some idea of the medical work the Navy did, one bullet went through the left arm, one hit me in the left side, went through my lung, hit my heart, went through my diaphragm, stomach, intestine, spleen, gall bladder, adrenal gland—then I went down! After that I was hit by two grenades—I never lost consciousness until I got on the hospital ship—they performed a miracle, a real miracle.

Improved techniques of vascular surgery have made it possible for surgeons in the combat area to save limbs which would have been amputated in the past, and to reduce the major tissue destruction associated with amputation. Some estimates[3] indicate that 75% to 80% of limbs that would have been lost in World War II are now being saved.

In addition to the more complex general disabilities created by multiple wounds are the increased incidence of quadriplegia and paraplegia resulting from spinal cord injuries and the impairment caused by multiple amputation. This is noteworthy because of the need it has created for special types of long-term rehabilitation programs.

Thus far, the Veterans Administration reports that it has re-

ceived 2,372 Vietnam veterans transferred from military hospitals with paralysis resulting from injuries to the spinal cord. Of these, 35% are quadriplegics—a much higher proportion than was observed after prior wars. There are presently some 12,000 living veterans who have injury to the spinal cord; more than 1,000 of these are hospitalized at any given time in 14 Veterans Administration Spinal Cord Injury Centers.

Despite the technical gains which have been made, the Veterans Administration has received 5,090 service-connected Vietnam amputees. Of these, 18.1% have had multiple amputations. This incidence is much higher than that of the Korean conflict (9.3%) and World War II (5.8%). The magnitude of the rehabilitation program for amputees in the Veterans Administration is reflected in the fact that there are now 26,566 service-connected amputees from all wars on its rolls. In 1971 34,100 prostheses of all types were provided to Vietnam veterans alone.

Psychiatric Disorders

The incidence of psychiatric disorders has been lower in the Vietnam conflict than in previous wars. Bourne has reported an incidence of 12 per 1,000 for such casualties in all branches of the services in Vietnam, as compared to an incidence of 37 per 1,000 in Korea and 101 per 1,000 in World War II.[7] Thus far, 48,391 Vietnam veterans are receiving compensation for service-connected psychiatric and neurologic disorders. Nearly 11,000 were admitted to Veterans Administration Hospitals in 1971. There has been a significant increase in character and situational disorders over the more classical anxiety and conversion reactions, when compared to the experience in prior wars. The incidence of psychoses has remained approximately constant.

Thus far there has been no evidence of the delayed psychiatric illnesses that some experts have thought would result from the unique conditions of the Vietnam conflict. It had been predicted, for example, that guilt over participation in an unpopular war would create special emotional stress. Most servicemen, however, do find the hostile components of their reception upon returning home to be disturbing, but apparently it is not affecting their emotional stability to a significant extent.

Characteristics and Attitudes of Vietnam Veterans

A great deal has been written and said about the characteristics and attitudes of the Vietnam veteran. In much of this there has been a

tendency to generalize a number of limited experiences and observations; more often than not this has accrued to the disadvantage of the majority of Vietnam servicemen.

A recent poll of discharged Vietnam veterans, the general public, and employers, conducted by Louis Harris and Associates, Inc., has produced interesting information in this regard.[8] It has shown that the large majority of veterans have taken their military experience and their reception by civilians in stride, and have had little or no difficulty with readjustment. However, the general public polled made the observation that "the whole question of treatment of returning veterans is a serious burden on the conscience of the American public." The divergence is well expressed in one of the conclusions of the survey:

> While the American public and employers are keenly aware of how returning veterans *should* be treated and yet feel guilty about the way ex-servicemen *are* being treated, among veterans the story is different. The returning servicemen seems less preoccupied with the way things should be, and are content to accept things as given and do the best they can to readjust to civilian life. This passive acceptance holds for all groups except the alienated veterans—the non-white and non-high school graduates. Among these servicemen, there is a real feeling that society owes them something for their efforts.

A number of studies[9-11] of the characteristics and attitudes of the Vietnam Era veteran patients, which include the so-called "alienated group," have generated more detailed information. From these studies has emerged a descriptive personality profile of these veteran patients, which would seem to be equally descriptive of a large segment of the younger generation in our present society. Five characteristics were identified:

> *First*, he responds more assertively to authority and is willing to question and to challenge it.
>
> *Second*, he expects authority, nevertheless, to be unresponsive to him and to seek to control and suppress him. The term, "the establishment," carries this implication; being "turned off" characterizes his response.
>
> *Third*, he feels a general sense of uncertainty toward the future and a greater urge for fulfillment today—the "NOW phenomenon."

Fourth, he feels a kind of protective identification with his own age group, which he believes shares his uneasy perceptions of his society.

Fifth, he has less control over feelings and impulses, and is more impatient and impulsive.

Other studies[12, 13] have attempted to determine how and why Vietnam veterans differ from the veterans of previous wars and have concluded that the differing characteristics of the Vietnam veteran more than anything else reflect the increased complexity and ever-changing nature of the society of which he is a part. He views life with less conviction about established principles and values. He has been influenced by the necessity to fight in an unusual kind of war, in which political realities often must outweigh military necessities, and where enemy and friend may be indistinguishable. He is different because upon his return he has been treated very differently by the society he served. He does not return to the assured respect and appreciation of his countrymen. Instead, he typically returns to indifference, disapproval, and scorn—especially from peers who did not serve.

The returning Vietnam veteran believes he has served his country well, as indeed he has, but many have a sense of confusion, frustration, ambivalence, and anger. They easily become disenchanted and alienated, and become irritated and impatient with policies and procedures which they do not understand. They are especially sensitive to mechanical or impersonal treatment, or unresponsiveness to their human needs—particularly from an agency, such as the Veterans Administration, that has been charged with helping them.[14] Despite all this, they have a strong desire to achieve understanding by those around them, regardless of age, and to communicate openly and undefensively. When listened to, they communicate remarkably well; their criticisms usually are reasonable and "on target."

Abuse of Drugs

There has been a widespread tendency to link the drug problems of the Vietnam veteran to his personality and attitudinal characteristics. This is probably true, but only to a limited extent. In the experience of the Veterans Administration Drug Treatment Program it is significant that while 60% of the patients have been Vietnam veterans, the remainder have been veterans of World War II and of the Korean War.

Statistics compiled by the Department of Defense suggest that the incidence of "main line" heroin addicts is less than 1% of all Vietnam-era servicemen. This figure helps us establish the proper perspective. The Harris Poll tends to confirm this. By "private ballot," 2% of the national sample of veterans admitted some use of heroin. Not all of these can be considered serious users.

In fiscal year 1968, less than 2,000 veterans were admitted to Veterans Administration hospitals for treatment of their drug-abuse problems; in 1971 more than 11,000 were admitted. Except for some 700 active-duty servicemen transferred to Veterans Administration hospitals prior to separation, all of these veterans have sought treatment voluntarily. Thus far it has been impossible to obtain accurate indications of the total number of veterans who have a drug problem. From the Department of Defense and other studies, it seems reasonable to assume that there are about 50,000 to 75,000 "hard" drug users among veterans; these figures are no more than an educated guess. There are virtually no data regarding the magnitude of use of other drugs.

Of the veterans treated in Veterans Administration hospitals thus far, slightly more than half had been using narcotic drugs, predominantly heroin. The remaining half had been using other drugs, predominantly the barbiturates, hallucinogens, and marijuana. Several studies of small samples of these patients have generated information about their characteristics. A large percentage were associated with the so-called "alienated" segment of society: 60 to 70% were black, 90% had high school educations or less. Their ages ranged from 18 to 70-plus years. Sixty per cent had been arrested, and 30% admitted using drugs prior to service. Of those addicted to heroin, 40% became addicted in Vietnam, the remainder while on assignments elsewhere overseas and in the continental United States, or after service. More than half had had prior and unsuccessful treatment.

Presently, all of the 165 Veterans Administration hospitals with their associated 202 outpatient clinics can provide at least the initial phase of treatment for drug-abuse problems. Of these hospitals, 32 have special drug-treatment centers with multimodality treatment programs involving a short but comprehensive inpatient medical and psychological evaluation, detoxification when indicated, and the initiation of the specific treatment program deemed appropriate. These include methadone maintenance, abstinence, and experimental nonnarcotic blocking agents

—all based upon intensive psychotherapeutic and rehabilitation programs. Once established, treatment is continued in Day Hospital and Day Treatment Centers, therapeutic communities, and the more conventional outpatient clinics. Special emphasis is directed toward getting the patient into some type of productive activity—such as school, vocational training, or a job. Since many of the patients have never worked, the latter poses a particularly difficult challenge.

In order to maintain competency in the staff, various types of training programs have been created for physicians, psychologists, nurses, social workers, and vocational counselors. The use of ex-addicts trained as counselors has been especially successful in the maintenance of intimate day-to-day relations with patients.

The experience of the Veterans Administration Drug Treatment Program indicates clearly that the success of treatment depends on the motivation and commitment of the patient and on the ability of the staff to both stimulate these and respond to his needs. It is encouraging that an increasing number of veterans have turned to the Veterans Administration hospitals after other treatment efforts have failed; relatively few (about 20%) of these have dropped out of treatment.

The Vietnam Veteran and Employment

One of the major purposes of the Harris Poll was to determine how returning Vietnam veterans were faring in the job market. According to the study, the public, employers, and veterans agreed that most veterans were more mature and more stable than when they entered service, and thus were better qualified for jobs. Employers gave the highest positive ratings to enlisted men generally, recently returned, and those who had served in Vietnam and combat zones. Sixty per cent of all businessmen interviewed had hired veterans during the past year; those who operated small companies (20 employees or less) had employed proportionately more veterans than those who operated large companies.

Of the veterans interviewed, 15% were not working. Of this group, 4%, as students or for other reasons, were not in the labor market. However, the nonworking percentages for nonwhites and for those who had not finished high school were 21 and 31% respectively.

The Bureau of Labor Statistics reports that there are presently about 320,000 unemployed Vietnam-era veterans in the nation's labor force.

Fifty-nine per cent of the employed veterans expressed satisfaction with their jobs. The satisfaction of employers with the veterans they had hired was tied to the complexity of the job and to the amount of education and training required for it. Thus veterans in professional, technical, and administrative positions rated high. Employers were less enthusiastic about the performance of veterans in jobs requiring less skill; this becomes an added disadvantage to veterans who have had little education and training.

Summary

From this assessment of the characteristics and medical experience of the Vietnam veteran, it is concluded that the overwhelming majority have the potential to adapt to their society and to both academic and industrial environments better than their nonmilitary peers. A significant number have residual physical disabilities for which special types of training and employment will be necessary. Others have drug problems, the eventual outcome of which cannot yet be predicted. Veterans who are nonwhite and those with limited education and training present special problems which must be given attention.

It is also important to recognize that this generation of young persons, veterans and nonveterans, views the world of work and authority quite differently. Four factors seem to have a particular significance for young people today: integrity, involvement, responsiveness, and caring.

Thus this group of young veterans will do better in work situations where it is possible to convey to management the increased importance of more open, responsive relations with employees and of the involvement of employees in meaningful ways with the company and its products. Where possible, such attitudes could serve as examples of preventive medicine at its best.

REFERENCES

1. *The Vietnam Era Veteran, Challenge for Change.* Washington, D.C., Veterans Administration, 1971.
2. Heaton, L. D., Hughes, C. W., Rosegay, H., Fisher, G. W. and Feighny, R. E.: Military surgical practice of the United States Army in Viet Nam. *Curr. Probl. Surg.* pp. 2-59, November 1966.
3. Haacker, L. P.: Time and its effects on casualties in World War II and Viet Nam. *Arch. Surg. 98*:39-40, 1969.
4. Personal Communications. Office of the Surgeon General, Medical Statistics Section, U.S. Army.
5. Maughon, J. S.: An inquiry into the nature of wounds resulting in killed in

action in Vietnam. *Milit. Med. 135*:8-13, 1970.

6. Byerly, W. G. and Pendse, P. D.: War surgery in a forward surgical hospital in Vietnam: Continuing report. *Milit. Med. 136*:221-26, 1971.
7. Bourne, P. G.: *Men, Stress, and Vietnam.* Boston, Little, Brown, 1970.
8. Louis Harris & Associates, Inc.: *A Study of the Problems Facing Vietnam Era Veterans: Their Readjustment to Civilian Life.* Study No. 2131 for Veterans Administration, October 1971.
9. Braatz, G. A. and Lumry, G. K.: The young veteran as a psychiatric patient. *Milit. Med. 134*:1434-39, 1969.
10. Crumpton, E. and Mutalipassi, L. R.: The Young Veteran Patient. Meeting, *Western Psychol. Ass.*, April 1970.
11. Stuen, M. R. and Solberg, K. B.: The Vietnam veteran: Characteristics and needs. Meeting, *Amer. Psychiat. Ass.*, May 1970.
12. Peck, C. P.: The Vietnam veteran. *V.A. Newsletter Res. Psychol. 13*:11-14, 1971.
13. Sherman, L. J., Bourne, P., Fendrich, J., Stanton, M. and Stenger, C. A.: *Symposium: Today's Veteran.* Highlights, 16th Ann. Conf. V.A. Cooperative Studies in Psychiatry, St. Louis, Mo., March 1971.
14. Cleveland, S. E. and Lewis, F.: Attitudes of Vietnam era vs. WW II-Korean era veterans toward V.A. hospital practices. *VA Newsletter Res. Psychol. 13*:1-3, 1971.